Summary

Sweden has a long tradition of county council-run hospitals that have dominated the supply of health care at the same time as primary health care has accounted for a relatively small share of health care. This is the background to several ongoing government inquiries intended to strengthen primary health care and what is called *local health care*. Hospital health care is responsible for health care services like out-patient care at clinics, routine diagnosis and treatment, highly specialised care and emergency care services. At the same time, the university hospitals, in particular, have a responsibility for education and research. Hospitals are also dependent on cooperation with other forms of health care such as primary health care and subsequent interventions after discharge such as rehabilitation and elderly care. The trend in recent years has gone in the direction of parts of hospital health care being moved out to other health care providers. Here, the Swedish hospital system has been regarded as hospital-centred. Ongoing government inquiries have an overall objective of providing less health care at hospitals in order to achieve a health care system of greater overall efficiency.

This report makes a comparison of the hospital sector in a number of west European countries with a similar economic standard and similar living conditions and health status. The health care systems of these countries also display similarities regarding goals of universal access to health and similar cost levels. Several comparisons have classified health care systems in Europe as either tax-based or social insurance-based (Beveridge or Bismarck systems). The first part of this report uses this classification to give an account of the financing, structure, resources, performance, outcome measures and distributional aspects of the hospital sector. The tax-based countries are Denmark, Finland, Ireland, Italy, Norway, Portugal, Spain, Sweden and the UK. The social insurance

countries are Austria, Belgium, France, Germany, Luxembourg, the Netherlands and Switzerland. The second part of this report gives a more detailed account of the design of regulation, governance and payment systems for the hospital sector in four countries: the Netherlands, Germany, Denmark and Norway.

Purpose and starting points

The purpose of the report is to make a comparison of the hospital sector in a number of west European countries, and to set out the strengths and weaknesses of each country at the same time. A further purpose is to identify factors and governance mechanisms that can form the basis for differences in outcomes. The intention is to also discuss to what extent Swedish health care can learn lessons from how hospital health care is organised in other countries and to identify common trends. The added value of the report is that it provides knowledge and ideas about alternative ways of organising and governing the hospital sector.

One starting point for the report is the problems of waiting times and accessibility in Swedish hospital health care that have attracted attention, but also to take account of positive aspects of hospital health care in Sweden such as good results especially regarding medical quality and survival for several treatments. In Swedish health care and other tax-based systems, an integrated model of public funding and publicly owned hospitals has undergone some reform in recent years. For example, several regions now sign contracts with private health care providers for simple planned care. Since this development is taking place against the background of a previously fully integrated public production system, the experience of contracting out is still relatively limited. One added value of the report is that it points to lessons especially from countries with social insurance systems, which have long experience of governing and contracting hospitals in a more pluralist system with different forms of ownership. The major differences between tax-based systems and countries with social insurance systems are the division into funder and care provider and therefore the occurrence of agreements and contracts between parties. Reforms of the hospital sector in tax-based systems are also studied. This applies chiefly to the governance

by central government of independent regions responsible for health care. All the countries studied share universal access to health care services and mainly public funding.

Most of the sources used in the report are international, including the OECD, WHO and the Commonwealth Fund, but scientific publications and national reports have also been used. The supporting data has been supplemented with reports and statistics from the Swedish National Board of Health and Welfare, the Swedish Agency for Health and Care Services Analysis, the Swedish Association of Local Authorities and Regions (SALAR) and Statistics Sweden.

Public financing and the differences in health care structure

Initially, it is concluded that the differences between the countries studied are small regarding the financing of hospitals, including hospital health care. The social insurance countries have for a long time increased their public funding, and today most of the countries included have a public funding share corresponding to about 80 per cent of health care costs. The countries' costs of health care as a share of GDP show that most of the countries are in the interval of 7–11 per cent. This is higher than in many other OECD countries, but clearly lower than in the US. The question of the size of the hospital sector is more difficult to decide. According to existing OECD statistics, Sweden does not differ from the other countries in a remarkable way. But the statistics do show that, in an international comparison, Sweden has a low share of general practitioners and weak primary health care. At the same time, developments in Sweden shows that hospital doctors make up a large and rising share of the medical profession. The development of costs and investments also points to a hospital-dominated system.

Social insurance countries have a clearly higher share of privately produced health care in the hospital sector, which is dominated by non-profit hospitals. This results in a more pluralist hospital structure and there are more contracts and performance-based payments than in tax-based systems. Some of these countries also have public hospitals, mainly university hospitals.

The statistics on practising doctors and nurses show that, in an international comparison, Sweden does not have a shortage of

trained personnel. The density of doctors is higher than in most comparable countries and access to nurses is close to the average. Access to equipment based on commonly used technologies also points to good access.

Low productivity and long waiting times

Analyses of the relationship between resource inputs and performance (measured as labour productivity and overall hospital productivity) in previous studies have shown a clearly lower level for Swedish health care in general and hospital health care in particular. Even though there are methodological problems in productivity analyses, both international comparisons and developments in Sweden point to problems concerning the relationship between resource inputs and activity in Swedish health care, including hospitals.

Waiting times for planned treatments and operations done at hospitals have caused debate. International comparisons of waiting times are problematic as different ways of measuring waiting episodes are used. Here there are measurements based on register data for waiting times and interviews of patients and citizens. A reasonable interpretation of the statistics available is that tax-based systems have greater problems with waiting times than social insurance countries. One probable explanation of the problem of queues and waiting times in Sweden can be the low productivity. One contributing factor may be the high occupancy rate in Swedish hospital care, which indicates a shortage of hospital beds. This may then lead to problems with patient flows and treatment processes in hospitals.

High medical quality and equal care

Swedish hospital health care shows very good results regarding survival and medical quality. This chiefly applies to serious diseases like cancer, heart attacks and stroke. We can, however, see that several countries in the comparison are at about the same level. Sweden is also at the forefront concerning the introduction of new medical technology like day surgery and new treatment methods.

Here several countries with social insurance systems show slower application and development of day surgery, for instance. The explanations of these results are not fully established, but work in Sweden on national guidelines and on quality registers is highlighted as a cause. Another explanation may be what is, in an international comparison, good and equal health status and a high standard of living.

The countries studied have goals about universal access to health care and an equal distribution of health service use. The international comparisons of equal service utilisation do not point to any great differences between tax-based systems and social insurance systems. The differences that are found are explained by individual features like high patient charges and special forms of care intended for certain groups in individual countries. The analyses of the distribution of service use do not suggest that Swedish hospital health care is more or less equal than this care in other countries. In general, there is a pattern in which primary health care is consumed to a greater extent by low-income earners, while other specialised care (in Sweden mainly at hospitals) is used by high-income earners. In-patient care, with admissions of patients, is used to a greater extent by low-income earners.

The results of the international comparisons are summed up in the following table setting out strengths and weaknesses in Swedish hospital health care.

Strengths	Equivalent	Weaknesses
Medical quality	Level of costs	Productivity
New medical technology	Public funding	Waiting times/accessibility
Drug use	Access to staff	Bed occupancy/shortage of hospital beds
	Equipment	
	Equal care	

The second part of the report studies the hospital sector's structure, regulation, application of payment models and forms of employment in four selected countries. Relevant experience from Germany and the Netherlands (social insurance) and from Denmark and

Norway (tax financing) is summarised on the basis of problems relevant to the Swedish hospital sector. The problems studied are:

- Collaboration and agreements between hospitals and specialised care outside hospitals
- Payments, agreements and incentives
- Supply of and access to care outside office hours
- Central government role: training, investment and monitoring.

Alternative forms of employment

The forms of employment for doctors in particular differ between tax-based systems and social insurance systems. It is much more common to have hospital-employed doctors in tax-based systems and a smaller proportion of the medical profession to be self-employed in these systems. One advantage of employed personnel is the possibilities for control and governance of activities. One advantage of contracting is that the incentive structure is clearer; but, at the same time, organisers and financiers give up possibilities of direct governance and collaboration. Experience from Germany and the Netherlands shows that contracting-out and the organisation of the medical profession in groups of doctors require regulation and agreements that do not relate solely to own core services. Agreements with independent groups of doctors or the equivalent therefore also cover responsibility for training and for out-of-hours and on-call services. For example, participation in out-of-hours and on-call services and in certain training may be required for payment from the public insurance. At the same time, doctors with their own practices are able to have their patients admitted to hospital.

The development of hospital health care in Sweden shows that parts of specialist health care are increasingly contracted out to private health care providers, but there are, at the same time, no commitments regarding training and participation in on-call services, for instance. Procurement and health care choice systems often focus only on deliveries as the number of consultations,

operations, patients treated, etc., and contain relatively little other regulation. Here, lessons can be learned from how contracts and agreements with actors outside the hospital sector are designed in countries with social insurance systems. Against the background of the recruitment problems in Swedish health care, greater flexibility for employment forms and contracts with health care employees can lead to better use of human capital in health services.

The advantage of contracting out planned health care is better access to non-acute care and shorter waiting times. At the same time, other needs such as the staffing of the emergency departments of acute hospitals and other provision of care outside office hours must be satisfied. Here, there are several examples of countries with social insurance systems in which financiers and health care providers use both regulation and incentives so that employees working outside hospitals in their own practice also participate in out-of-hours services at emergency departments. Collaboration between hospitals and the range of health care available outside hospital outside office hours also provides possibilities for better accessibility.

Payment and incentives

The development of payment systems for hospitals and staff at hospitals has changed in several countries, and for the hospital sector this has meant that, to a great extent, in-patient care now receives payment for the number of patients treated according to the system of diagnosis-related groups (DRGs). This payment principle is based on hospitals receiving a fixed payment for the whole of the care episode at the hospital. Previous payment principles that were based on the number of in-hospital days (Germany), the performance of component services (Belgium, Netherlands), budget (Nordic countries and UK) have been phased out in favour of the DRG system. However, developments in Sweden show a return in budget appropriations in several regions, even though DRG continues to be used as a monitoring instrument.

In several countries payment systems are being developed to adapt to new ways of working, forms of organisation, treatment methods and new technology. This applies especially to the design of performance- and quality-based payment systems for new types

of services and ways of working. One aspect that emerges clearly from a comparison of tax-based and social insurance systems is the forms for the role of the profession in negotiations of payment systems. In both Germany and the Netherlands principals, such as insurance companies, hospitals and health insurance funds, negotiate with medical associations in various specialities. Corresponding agreements in Sweden are drafted by the regions/county councils, and in them accreditation criteria, payment systems and other contractual terms are laid down without any direct negotiations with the profession. One advantage of negotiated agreements is that they provide both a clearer influence for the profession and a better commitment on the part of the profession to the content of the agreement.

A contractual form between principals and care providers is generally most suitable in a system with public funders in which most health care production is carried out by private providers. It is relatively rare to have negotiations in a publicly governed organisation with legally binding agreements between representatives of purchasers and health care providers. Despite this, however, regions in Sweden have direct negotiations with the private actors that currently operate mainly in primary health care and in outpatient care and in planned care outside hospitals. With negotiations, as in Germany and the Netherlands, the profession is given more influence at the same time as undertakings like accessibility, participation in the out-of-hours organisation, responsibility for training, etc., are made clear.

Access to care outside office hours

The load and demand pressure on hospital emergency departments is a problem found to a varying degree in several countries. There is relatively great agreement that acute medical problems can be dealt with to a greater extent outside the acute hospitals. The few international studies carried out show that in several countries, including Sweden, a larger share of patients make their way to emergency departments on account of the lack of alternative health care outside office hours. In Belgium and Denmark this figure is clearly lower, demonstrating the possibilities of steering patient

flows to other alternatives. The countries that have expanded alternatives to hospital care and tried to steer patient flows to other health care providers include Denmark, the Netherlands and Norway. In the Netherlands a trial has been under way for some time of a system with, first, greater access to general practitioners outside office hours and, second, a special organisation for people with chronic diseases and older people with multiple illnesses that is available to some extent outside office hours. The Danish model of standardised and accredited patient flows is based on a similar discussion (the Danish Healthcare Quality Programme).

The central government should not run, but have clear influence and control

Central government has an important role, in both tax-based systems and social insurance systems, in providing overall responsibility, regulation and governance of various actors. In the four countries studied in the second part of the report there is relatively far-reaching decentralisation on the actual running of hospitals. The exception is Norway, where a state corporate organisation has taken over the running of hospitals. In Germany and the Netherlands private non-profit organisations dominate as owners of hospitals. However, central governance is more extensive for the further training and specialisation of doctors, in particular, than in Sweden. In Sweden there has historically been far-reaching decentralisation of responsibilities and powers in the hospital sector in particular, with considerable degrees of freedom and autonomy for the regions in Sweden. This applies, not least, to responsibility for further training and specialisation of the medical profession. Clearer central government governance in this area may be a key to a higher share of general practitioners and reinforced primary care. Decisions on investments in new construction and alterations and on purchases of advanced equipment are made without central government control and regulation.

Other areas in which central government in these four countries has more influence are the development of governance and payment models. This applies chiefly to development work and the budgetary frameworks for resource allocation. In contrast, negotiations and contractual relations are often decentralised to regional or private

actors, even though central government has good insight into and control of the design of these agreements and contracts, e.g. in Denmark and Germany. Another important area is monitoring of both productivity and efficiency and of distributional aspects, in which national agencies or institutes continuously track developments. The Danish model is of interest here; in it central government has a requirement of a positive productivity growth in the hospital sector.

The hospital sector in Sweden is facing several challenges. Developments in recent decades with a privatisation of forms of health care, especially planned hospital care, have meant that Sweden and other countries with tax-based systems are approaching the structure found in countries with social insurance systems. Here, there are lessons to be learned about how regulation, payment systems and employment contracts can be designed to achieve an efficient health care structure when health care is contracted out. Another central issue discussed is whether central government should increase its influence on the hospital sector and take over the running of hospitals. There is, however, weak support for such a restructuring in other countries, irrespective of system. The role of central government in the countries studied relates not primarily to a nationalisation of forms of management, but to a clear, long-term role for questions concerning the regulation of training, investment and infrastructure and for monitoring of efficiency and distributional aspects.